Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
CENTENNIAL MEDICAL CENTER
c/o MATTHEW O'NEIL
ATTORNEY

Respondent Name
INDEMNITY INSURANCE CO OF NORT

Carrier's Austin Representative Box
Box Number 15

MFDR Tracking Number
M4-15-1237-01

MFDR Date Received
December 22, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim was initially denied. The matter was then assigned to legal counsel and a "request for reconsideration' was sent on 9/24/14. On or about 1-23/14 as check was sent to the hospital. Counsel for the Hospital was not made aware of the payment and filed a Request for Benefit Review Conference on 11/12/14. That BRC was set for January 14, 2015.

After the request for BRC was filed, counsel learned of payment being remitted in the amount of $8,859.92. However and as set forth below, the claim had been underpaid. Counsel was also not made ware that a Benefit Dispute Agreement was entered into by the carrier and the claimant on 9/22/14. Counsel did not receive this agreement until 12/15 by email from a carrier representative. See attached …

Therefore, the Hospital submits this Medical Fee Dispute. The Hospital and its counsel did not learn of the BRC agreement until 12/15/14. Initial payment was remitted for the claim after said agreement on 10/23/14. The Texas Administrative Code provides that a medical fee disputes can be filed within 60 days after the date the Requestor receives the final decision relating to compensability or extent.

Thus, the Hospital is entitled to 143% of Medicare or $15, 286.99. To date the carrier has only paid $8,859.92. The Hospital seeks additional payment of $6427.07."

Amount in Dispute: $15,286.99

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We represent GENEX Services, Inc. and its client, Indemnity Insurance Co. of North America, ("Respondent"), in the above-captioned medical fee dispute. We are writing to provide a response/ position statement to Centennial Medical Center's Medical Fee Dispute Resolution Request requesting payment of an additional $6,427.07.

Centennial Medical Center ("Petitioner") is not entitled to additional payment for the disputed services that are the subject of this Medical Fee Dispute. Petitioner seeks a total amount of $15,286.99 in connection with services rendered to Claimant [injured employee] on October 21, 2013 through October 23, 2013. Respondent has previously submitted payment in the amount of $8,859.92."

Response Submitted by: Brown Sims

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 21, 2013 to October 23, 2013	Inpatient Hospital Surgical Services	$15,286.99	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, *37 Texas Register 3833*,applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.
3. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 468 – Reimbursement is based on the Medical Hospital Inpatient Prospective
   - P12 – Workers' Compensation Jurisdictional Fee Schedule Adjustment
   - A1 – Description not available
   - 718 – Payment denied based on claim status start/cut off dates

Issues

1. Were the disputed services filed in a timely manner?
2. Is extent of injury issue resolved?
3. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
4. Which reimbursement calculation applies to the services in dispute?
5. What is the maximum allowable reimbursement for the services in dispute?
6. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. 28 Texas Administrative Code 133.307(c)(1)(B) states that "A request may be filed later than one year after the date(s) of service if:

   (i) a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability.

   In the requestor's position statement states "Counsel did not receive this agreement until 12/15 by email from a carrier representative. See attached … Therefore, the Hospital submits this Medical Fee Dispute. The Hospital and its counsel did not learn of the BRC agreement until 12/15/14."

   Review of submitted DWC FORM 24 / BENEFIT DISPUTE AGREEMENT provided by the requestor finds it was submitted within the 60 day time frame in accordance with 28 Texas Administrative Code 133.307(c)(1)(B). The requestor states in it's position statement that "Counsel did not receive this agreement until 12/15 by email from a carrier representative. See attached."
2. 28 Texas Administrative Code §133.305(b) states "Dispute Sequence. If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability, or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021."

   Per the requestor's position statement states "the claim was initially denied." A PLN-1 dated October 18, 2013 from Sedgwick states "Carrier denies claim in its entirety …"

   Review of submitted documentation finds DWC FORM 24/ BENEFIT DISPUTE AGREEMENT provided by the requestor which the disputed issue of compensability is resolved. Per the DWC 24 Agreement states "The

parties agree that the Claimant did sustain a compensable injury on 08-19-2013. The parties agree that the Claimant did not have disability resulting from an injury sustained on 08-19-2013, from 08-20-2013 through 02-23-2014."

3. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."

   No documentation was found to support the existence of a contractual agreement between the parties to this dispute; therefore the MAR can be established under §134.404(f).

4. §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 143 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

   No documentation was found to support that the facility requested separate reimbursement for implantables; for that reason the MAR is calculated according to §134.404(f)(1)(A).

5. §134.404(f)(1)(A) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov. Documentation found supports that the DRG assigned to the services in dispute is 491, and that the services were provided at Centennial Medical Center. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of $6,179.27. This amount multiplied by 143% results in a MAR of $8,836.36.

6. The division concludes that the total allowable reimbursement for the services in dispute is $8,836.36. The respondent issued payment in the amount of $8,859.92. Based upon the documentation submitted, no additional reimbursement is recommended.

Conclusion

For the reasons stated above, the division finds that no additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	3/26/15 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.